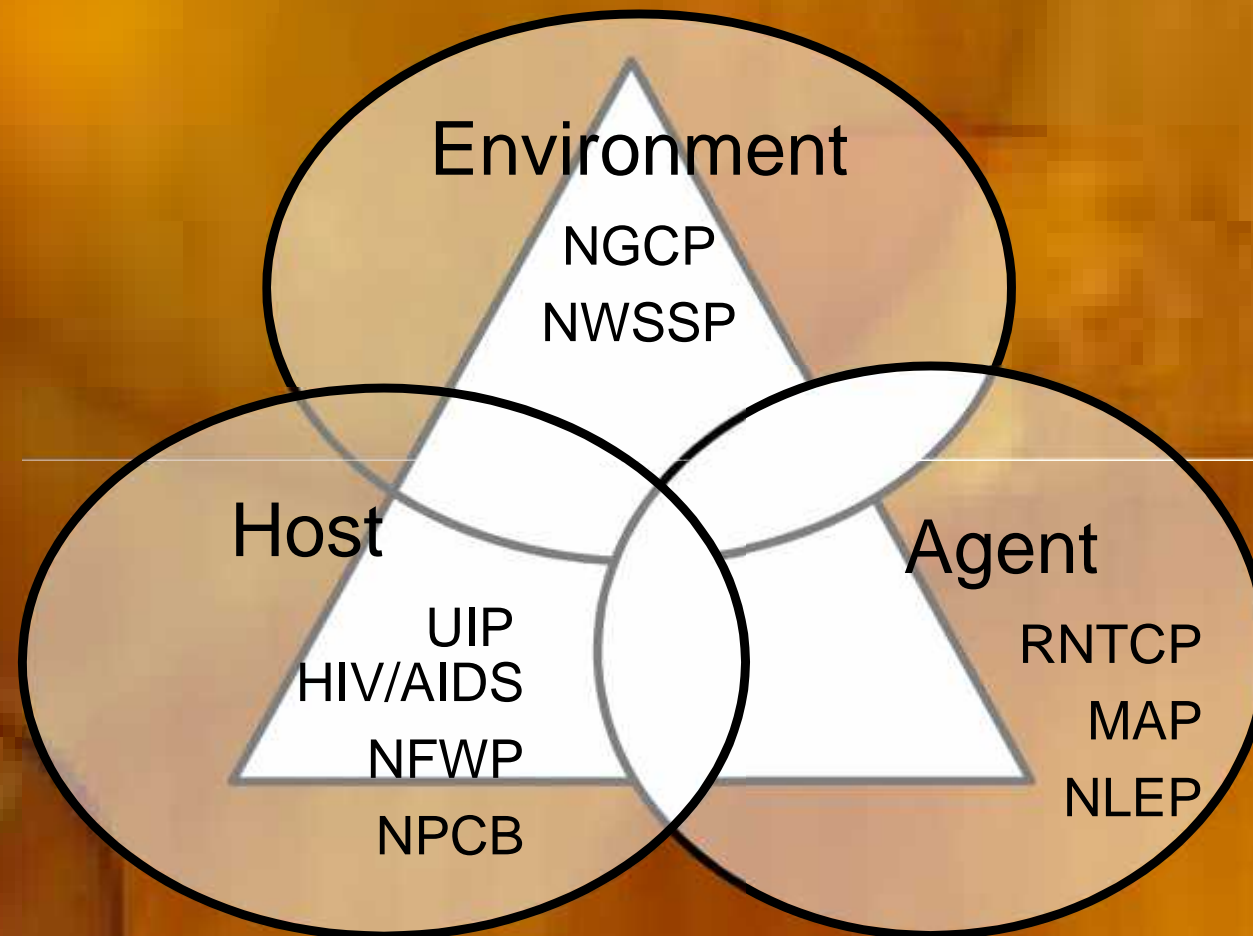




National Health Programs

State Institute of Health and Family Welfare,
Jaipur

Programs Address to





Milestones



HSDC-1946

NFPP-1952
India Joins WHO-1948



Alma Ata-1978
Small pox eradicated-July 5, 1975

UIP-1985
NHP-1983

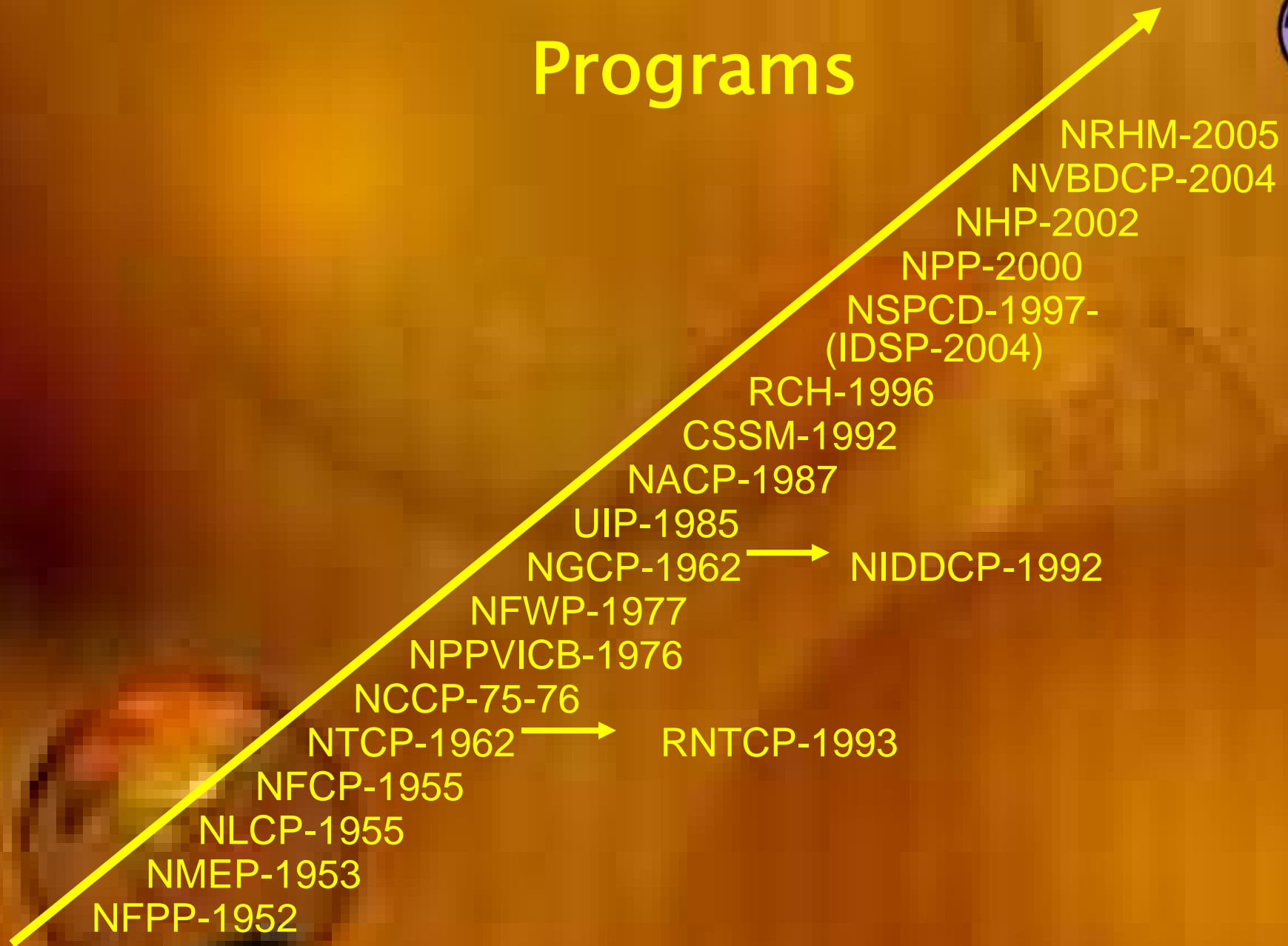
RCH-1996

NRHM-2005
NHP-2002
NPP-2000





Programs



Program Components

- Need
- Goals & Objectives
- Strategy
- Approach
- Activity
- Indicators
- Monitoring & Evaluation
- Financing

Major Programs

- National AIDS Control Program
- National Cancer Control Program
- National Diarrheal Disease Control Program
- National Filaria Control Program*
- National Family Welfare Program
- National Iodine Deficiency Disorders Control Program
- National Leprosy Eradication Program

- National Malaria Eradication Program*
- National Program for Control of Blindness & Visual Impairment
- National Reproductive and Child Health Program
- National Program for surveillance Program for Communicable diseases
- National Tuberculosis Control Program (Revised)

(Programs are merged into*

National Vector Borne Disease Control Program since 2003-04)



Minor Programs

- National Mental Health Program
- National Japanese Encephalitis Control Program*
- National Diabetes Control Program
- National Kala-azar Control Program*
- National Water Supply and Sanitation Program

(Programs are merged into*

National Vector Borne Disease Control Program since 2003-04)



National Family Welfare Program (NFWP)



National Family Welfare Program

- 1951, 100% Centrally Sponsored, concurrent list
- First country in the world
- Family Welfare Dept.- created in 3rd FYP
- 4th FYP - integration of Family Planning services with MCH services
- MTP Act introduced 1972

Approach

- 1st and 2nd FYP- “Clinical”
- 2nd FYP - “Target approach”
- 3rd FYP – “Extension & Education” approach
- 4th Plan - Post Partum scheme, reduce CBR to 32
- 5th Plan – NFPP replaced by NFWP, reduce CBR to 30
- 6th Plan - Net Reproduction Rate (NRR) of 1, family size to 2.3
- 7th Plan - spacing methods, community participation and promotion of MCH care

Approach

➤ VII FYP

- Area Development Projects
- India Population Project-VIII & IX
- India Population Project-VIII & IX
- Differential planning scheme
- Increasing involvement of NGOs
- UIP & CSSM
- TFA

IX FYP

Indicator	If current trend continues	If acceleration envisaged in Approach Paper to the Ninth Five Year Plan is achieved.
CBR	24/1000	23/1000
IMR	56/1000	50/1000
TFR	2.9	2.6
CPR	51%	60%
NNMR	35/1000	
MMR	3/1000	

➤ X FYP –

- Objectives:
 - Reduction in the decadal rate of population growth between 2001 and 2011 to 16.2%;
 - Increase in Literacy Rates to 75 per cent within the Tenth Plan period (2002 to 2007)
 - Reduction of Infant mortality rate (IMR) to 45 per 1000 live births by 2007 and to 28 by 2012

X-FYP

➤ Population Policy

➤ NRHM

- IMR,MMR,TFR
- Unmet Needs- Increasing Contraceptive choices
- Male involvement
- Social marketing
- Private sector involvement
- Infrastructure strengthen
- Involvement of PRI
- IEC
- Training

XI FYP

➤ Targets

- Reduce IMR to 28 and MMR to 1 per 1000 live births
 - Reduce TFR to 2.1
 - Provide clean drinking water for all by 2009 and ensure that there are no slip-backs
 - Reduce malnutrition among children of age group 0-3 to half its present level
 - Reduce anemia among women and girls by 50% by the end of the plan
- Family planning insurance Scheme
 - Jansankhya Sthirata Kosh

Goals: XI FYP

- Reducing MMR to 100
- Reducing IMR to 28
- Reducing TFR to 2.1
- Providing clean drinking water for all by 2009
- Reducing malnutrition among children of age group 0–3 to half its present level.
- Reducing anemia among women and girls by 50%.
- Raising the sex ratio for age group 0–6 to 935 by 2011–12 and 950 by 2016–17.

Empowered Action Groups

- GOI constituted an EAG w.e.f. 20th March, 2001
 - To facilitate the preparation of area-specific programs,
 - With special emphasis on eight states
[Rajasthan, UP, Bihar, MP, Orissa,
Chhattisgarh, Jharkhand, Uttaranchal]

Role of the EAG

- Ensuring appropriate policy development at the Centre,
- Provisioning for technical assistance to the member States,
- Addressing issues of coordination between member states and departments
- Deploying financial resources, as appropriate and feasible.



Family Planning Insurance Scheme

- To encourage people to adopt permanent method of Family Planning
- Centrally Sponsored Scheme since 1981 to compensate the acceptors of sterilization for the loss of wages
- Implemented through ICICI Lombard General insurance Company
- Compensation: (w.e.f-07.09.07)
- Compensation in case of adverse event (w.e.f. January 1st, 2009)

Family Planning Insurance Scheme:



Compensation: (w.e.f-07.09.07)

In Govt. facilities-

Category	Intervention	Acc epto r	Moti vato r	Dru gs	Sur geo n	Anes theti st	Sta ff nur se	OT Ass tt.	Ref res hm ent	Ca mp mgt.
High focus states	Vasectomy (all)	1100	200	50	100	-	15	15	10	10
	Tubectomy(all)	600	150	100	75	25	15	15	10	10
Non high focus states	Vasectomy (all)	1100	200	50	100	-	15	15	10	10
	Tubectomy(BPL, SC/ST only)	600	150	100	75	25	15	15	10	10
	Tubectomy(APL only)	250	150	100	75	25	15	15	10	10

In Pvt. Facilities–

Category	Type of operation	Facility	Motivator	Total
High Focus States	Vasectomy (All)	1300	200	1500
	Tubectomy (All)	1350	150	1500
Non High focus states	Vasectomy (All)	1300	200	1500
	Tubectomy (BPL+SC/ST)	1350	150	1500

Jansankhya Sthirata Kosh

- National Population Stabilization Fund - registered as an autonomous Society
- Combination of government and civil society
- Working to promote innovations
- Promote initiatives which leverage the strength of different economic and social sectors
- To reach out needy population groups

- Observation of World Population Day
- Prerna Awards at Dhaulpur and Jodhpur in Rajasthan and Nabarangpur in Orissa
- Working with the Private Sector Medical Specialists to enhance services for contraception.
- Induction of professional people [NGOs, CII, FICCI, IASP, IPHA, IAP & SM, FOGSI etc]
- Material Development and display for IEC/BCC

Innovative Strategy Under JSK “Prerna”



“Prerna” provides reward for specific parenthood

- Girl's marriage after 19 years - Rs.5000
- First birth after 21 years - Rs.7000 (girl)
Rs 5000 (boy)
- 3 years gap between first and second child with sterilization of 1 parent after the 2nd child (Reward of Rs.7000/ if it's a girl child & Rs 5000/ if it's a boy)



Conditions for Getting Rewards

- Couple must belong to any of the 46 districts identified
- Must belong to BPL category
- Preference given to younger couples
- Only those couples who have completed registration of marriage and registration of the birth of each child
- The award shall be given in form of Kisan Vikas Patra in the name of Couple and will be given at a public function

"Santushti"

- Motivate private gynecologists to perform 100 tubectomy/vasectomy, doctors are paid according to already notified compensation rates (Rs 1500 per case)
- MOU is signed between the district CMHO and private facilities
- Funding is provided by JSK through the Collector and CHMO
- Initiated in Madhya Pradesh, Rajasthan and Orissa
- 64 MOUs and around 1600 sterilization operations [until Aug 09]



Virtual Resource Centre (VRC)

- VRC is a virtual resource/documentation centre
- Provides access to films, posters, photos
- Subjects like anemia, gender, maternal and infant mortality, sex ratio, adolescent health, spacing etc.
- Media, Researchers, Students NGOs and General public has access to it
- Inter-university and school level quiz competitions



National AIDS Control Program



National AIDS Control Program

HIV/ AIDS

A Acquired must do something to acquire

I Immune ability to fight disease

D Deficiency

S Syndrome cluster of symptoms characteristic of disease

- First case: 1986
- National AIDS control program: 1987
- NACO: 1992

HIV/ AIDS Prevalence Criteria

- High: > 1% in Ante-natal women
- Moderate: < 1% in Ante-natal,
> 5% in STD/other high risk behavior
- Low: < 1% in Ante-natal &
< 5% in STD/other high risk behavior





Some facts

- **One** disease
- **Two** Viruses
- **Three** transmission modes-
 - Sexual
 - Vertical
 - IV Drug/Blood



- **Four** interventions
 - Communication
 - Counseling
 - Condoms
 - Care of PLWA
- **Five** owe responsibility
 - Individual
 - Family
 - Community
 - Care providers
 - Media



Facts

Source: Annual Report NACO-2010-11

People living with HIV/AIDS 1.9 – 3.0 million

Adult Prevalence –0.31%

Males - 0.36%

Females - 0.25%

Prevalence:

Antenatal clinic HIV : 0.48%

STD clinic HIV : 2.5%

IDU HIV : 9.2%

MSM HIV : 7.3%

Female sex worker HIV : 4.9%

NACP Phase-I (1992-99)

➤ Key Objective-

- Slow the spread
- Reduce- morbidity/mortality/impact

NACP-I Components:

- Strengthening management Capacity
- Promoting public awareness & comm. Support
- Improving blood safety from 30 to 90% & rational use
- Controlling STDs
- Building surveillance & clinical mgt. capacity



Key factors Affecting Project

- New program, little capacity to address
- Society & professionals unaware of HIV
- Difficult to identify, reach & cover risk group
- Linkages to STD/Tuberculosis inadequate
- Borrower's & recipients non-familiarity with project processing requirement
- Lack of ownership by States
- Lack of uniformity of process & infra-structural support
- Delay in release of funds



NACP phase-II(1999-2004)

- Nov.9, 1999
- 100% Centrally sponsored
- 32 States/UTs & 3 Municipal Corporations
- Participatory Planning- NACO/State/NGOs /Private sector/ stake holders-Approved by Cabinet-August 26, 1999

NACP Phase-II: Key Objectives

- Reduce spread of HIV in India
- Strengthen India's capacity to respond to HIV/AIDS on a long term basis



NACP–Phase II: Objectives:

- Shift in focus (Awareness → Behavior)
- Encouraging voluntary testing
- Support structured & evidence based
- Reviews & ongoing operational research
- Encourage Mgt. Reforms & Ownership
- Decentralization- Program delivery to be
 - Flexible
 - Evidence based
 - Participatory
 - Local base



NACP Phase-II : Components:

- Delivery of cost effective interventions
- Strengthening capacity





NACP Phase- II Performance Indicators

- HIV prevalence- 5% in Maharashtra
3% in TN+AP+Manipur
& Karnataka
< 1% in other States
- Reduce blood borne transmission <1%
- Awareness level of 90% in youth & Rep. Age group
- Condom use level of not < 90% among high risk groups-CSWs.

India Responds– Dec.2001

- 11 care & support centres
- 145 voluntary testing centres established
- 77 National Telephone help lines#1097
- 115000 mothers counseled, transmission rate down to 9.6%
- National AIDS Control Policy
- National HIV Testing Policy
- National Blood Policy



National AIDS Control Policy

Aims at-

- Prevention through awareness about implications & providing protection measures
- Provide enabling social environment to people & families with HIV/AIDS
- Improve services, for PLWA, in hospitals & at home through community health care

AIDS Control Strategy

- Program management
- Surveillance & Research
- IEC & Social mobilization through NGOs
- Control of STDs
- Condom programming
- Blood safety
- Impact reduction



NACP-III (2006-2011) Goals and Objectives

- Halt and reverse the epidemic
- Integrate Programs for prevention, care & support and treatment



National AIDS Control Program Phase III



Objective

- Prevent infections
- care, support and treatment to PLHA.
- Strengthen- infrastructure, systems and human resources
- Strengthen the Strategic Information Management System



National AIDS Control Program Phase III

Specific objective

- Reduce new infection as estimated in the first year of the program by:
 - Sixty per cent (60%) in high prevalence states
 - Forty per cent (40%) in the vulnerable states so as to stabilize the epidemic.



Strategy

- Targeted Interventions
- The Link Worker Scheme
- Preventive interventions for the general population
- Sexually Transmitted Infections (STI) Services
- Mainstreaming HIV for multi-sectoral response
- Condom Promotion
- Blood Safety
- Other activities for Blood safety



Strategy

- Care, Support and Treatment PLHA
- Institutional Strengthening and Capacity Building
- Strategic Information Management
- Monitoring and Evaluation
- Improving CMIS and overall Reporting
- HIV Sentinel Surveillance

Mainstreaming HIV

- Constitution of the State Councils on AIDS (SCA)
- Greater Involvement of People Living with HIV (GIPA) under NACP-III
- Mainstreaming with civil society organizations

Blood Safety

Aims

- Ensure provision of safe and quality blood
- Ensure reduction in the transfusion

Strengthening of Blood bank facilities through:

- District level Blood Banks
- Blood Component Separation Units
- Blood Storage centres
- Blood Refrigerated Vans



Care, Support and Treatment for People Living with HIV/AIDS (PLHA)

NACP III includes Comprehensive management of PLHA with respect to

- Treatment and prevention of opportunistic infection
- ART
- Psychosocial support
- Home based care
- Positive prevention and impact mitigation



The target for National ART Program

- Free ART to 300000 adult, 40000 pediatric PLHA by 2012 through 250 ART and 650 link ART centres.
- Achieve and maintain high levels of adherence and minimize numbers lost to follow up
- Involve inter sectoral partners, NGOs and Private partners
- Provide comprehensive care, support and treatment through 350 Community Care centres by 2012

Monitoring and Evaluation

- Development of an integrated M&E Plan for NACP-III
- Strengthening systems for better M&E
- Improving Component Specific M&E
 - ART centres
 - ICTC
 - STI/RTI Reporting
 - Community Care centres



HIV Sentinel Surveillance

- Surveillance in India was started from 1985
- NACO established in 1992, sentinel surveillance for HIV/AIDS in India.





Objectives of HIV Sentinel Surveillance

- Determine the level of HIV infection
- Understand the trends of HIV epidemic
- Understand the geographical spread of HIV infection
- Provide information for planning the Program
- Estimate HIV Prevalence and HIV burden



National Vector Borne Disease Control Program (NVBDCP)





National Vector Borne Disease control Program (NVBDCP)

NAMP

NFCP

Kala-azar control Program

Dengue/Dengue Hemorrhagic fever and
Japanese Encephalitis (J.E.)

merged as **NVBDCP**

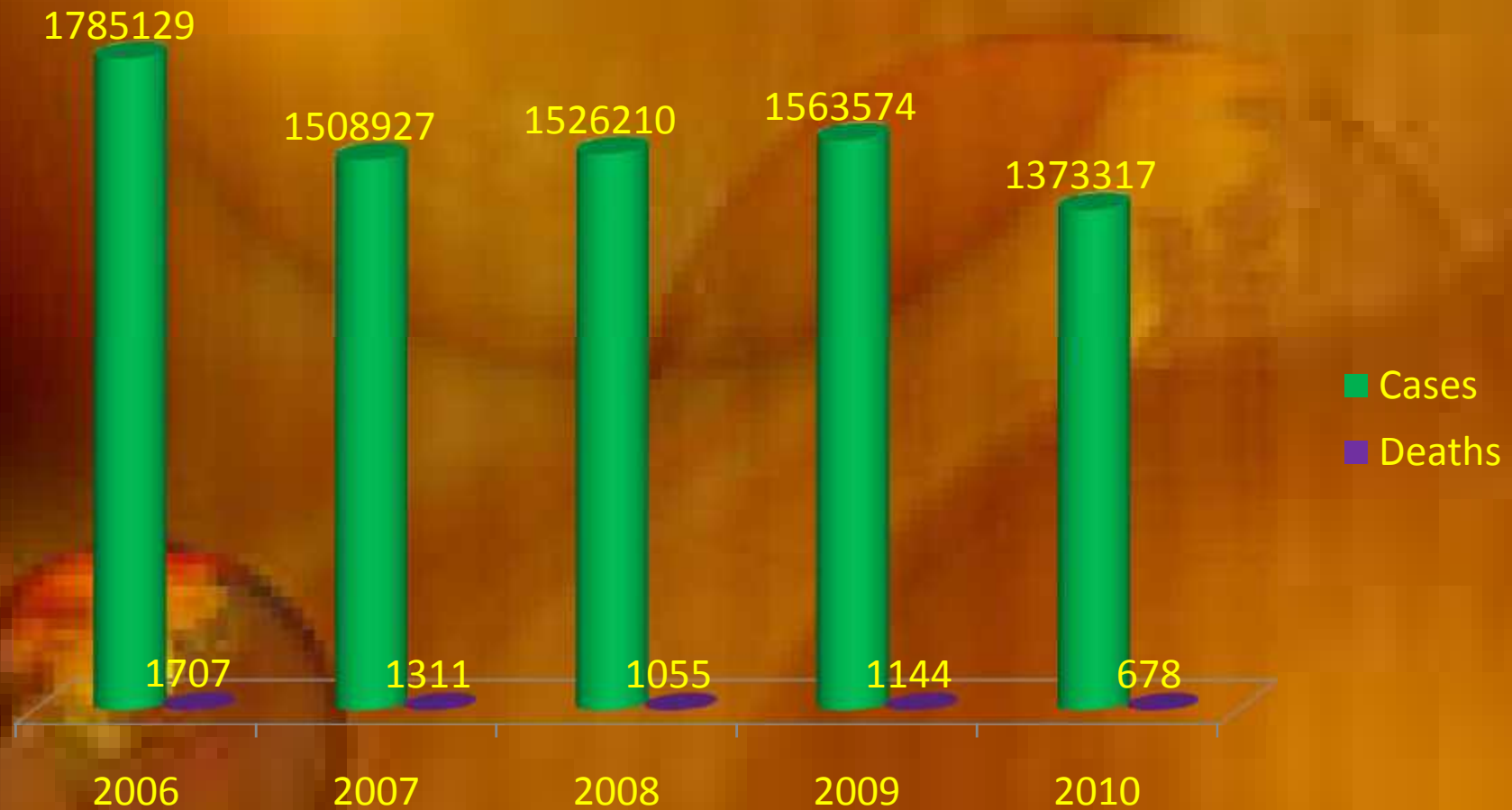


Malaria Control Program

- 1953 : NMCP launched
- 1958 : NMEP launched
- 1971 : Urban Malaria Scheme (UMS)
- 1976 : Resurgence with peak- 6.47M cases
- 1977 : MPO & PfCP
- 1979 : Centrally sponsored, 50:50 basis
- 1985 : 2 million cases
- 1991 : Peak in Pf cases
- 1994 : Epidemic: Eastern India & Western Raj
- 1995: Malaria Action Plan
- Sept. 1997: EMCP
- Apr. 1999: NAMP
- 2004: NVBDCP



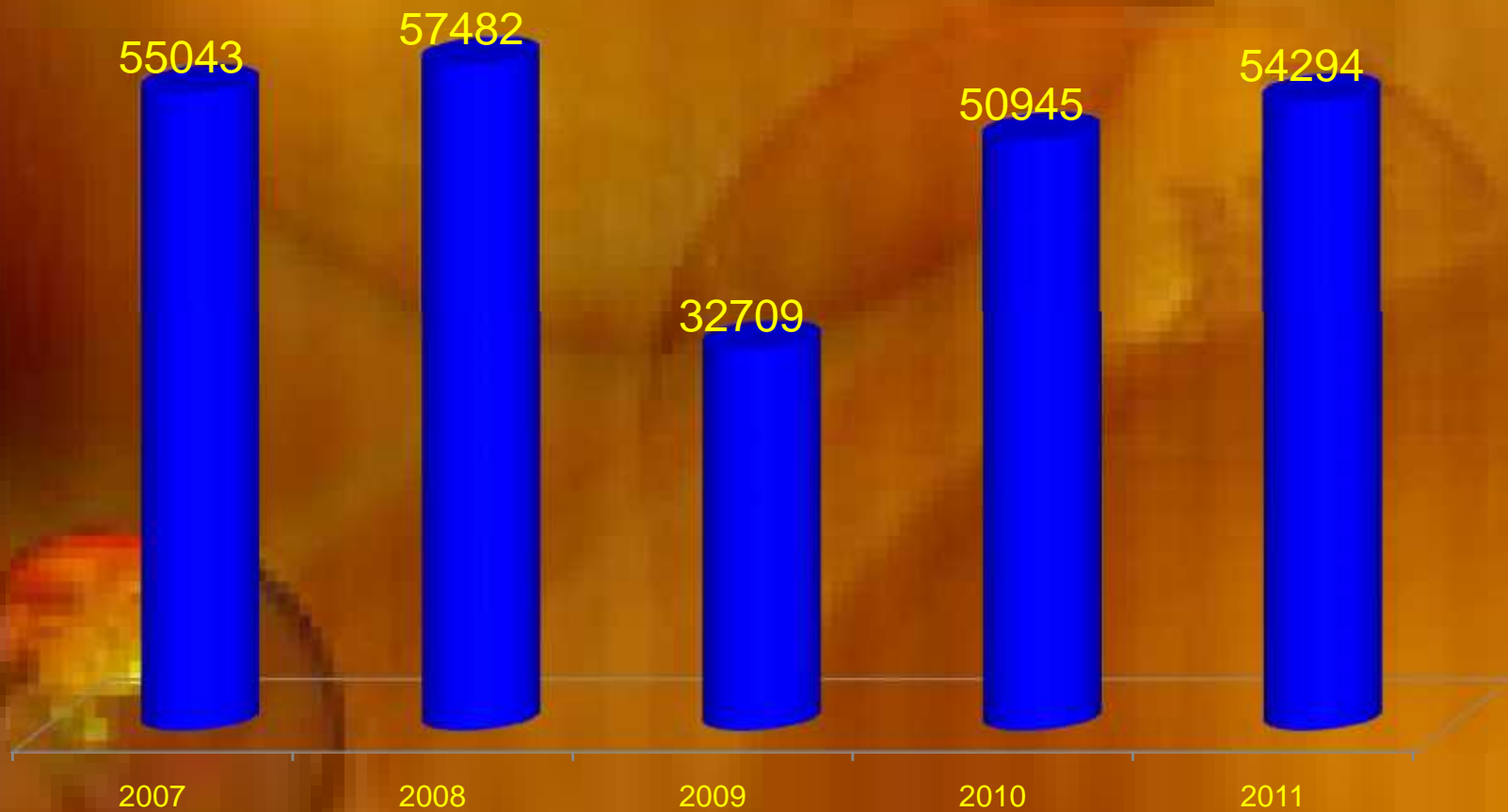
Malaria: India



Source: CBHI NHP 2010



Malaria Cases: Rajasthan



Source: MoHFW

Malaria Situation

Total Cases (2011-12):

India : 1075588

Rajasthan : 54294

Total Deaths (2011-12):

India : 754

Rajasthan : 45

Measuring Malaria

Human indices

- i. Annual Parasite Index (API)
- ii. Annual Blood Examination Rate (ABER)
- iii. Annual Falciparum Index (AFI)
- iv. Slide positivity rate (SPR)
- v. Slide Falciparum Rate (SFR)

Malaria Control

A. Management of cases

- Diagnosis- Blood slide (Thick & Thin)
- Treatment
 - i. Presumptive (With Chloroquine)
 - ii. Radical
 - iii. Mass drug administration (in areas with API>5)
- Chemoprophylaxis

Malaria Control

B. Interruption in Transmission

Vector control:

1. Anti adult measures-
 - a. Indoor residual spraying (IRS)
 - b. Space application
 - c. Genetic control

National Drug Policy: Malaria 2008



➤ Treatment-1:

a. chloroquine (25 mg/Kg for 3 days + Primaquine
(0.75 mg. /Kg for one day

Or

b. Artesunate (4 mg/Kg for 3 days)+sulpha
pyrimethamine (25/1.25 mg/ Kg single dose)
+Primaquine (0.75 mg /Kg single dose)

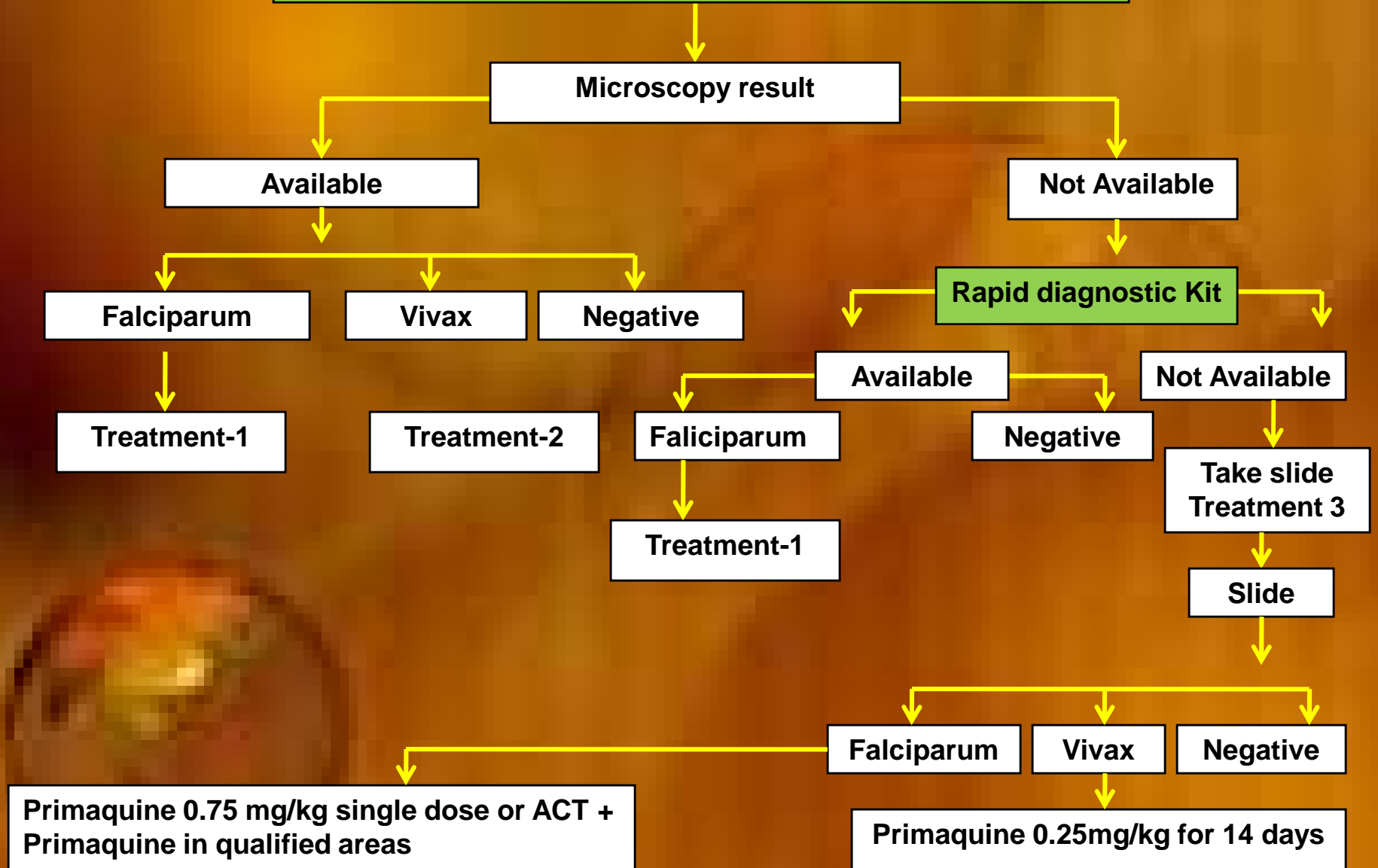
➤ Treatment-2:

Chloroquine (25 mg/Kg for 3 days+Primaquine (0.25
mg/ Kg for 14 days)

➤ Treatment-3:

Chloroquine (25 mg/Kg for 3 days)

Suspected (Clinically) Malaria Cases



Malaria Control Strategies

- Early Case Detection & Prompt Treatment (EDPT)
- Vector Control
 - Chemical Control
 - Biological Control
- Personal Prophylactic Measures
- Community Participation
- Environmental Management & Source Reduction Methods
- Monitoring and Evaluation of the Program



National Iodine Deficiency Control Program

Problem Statement

- World's single most significant cause of preventable brain damage and mental retardation.
- 261 million suffering from brain damage (10 million cretins)
- 130 countries, 13% of world's population.
- 9 million persons affected.
- 2.2 billion people live in ID areas
- 167 million at risk of IDD
- Goiter- 54.4 million

Problem Statement

- IDD mental/motor handicaps - 8.8 million
- 1984-86: ICMR multi centric study
 - 14 districts in 9 States
 - Goiter prevalence 21.1%
 - Endemic cretinism : 0.7%
- India : 241 of 617 Districts are Goiter endemic
- 140 million people are estimated to be living in goiter endemic regions
- 51% HH consuming iodized salt (State of World's Children, 2009-UNICEF)

Turning point of the program : 1983

- Questions asked by Mrs. Indira Gandhi
 - What is Iodine Deficiency?
 - Why should I be interested in National Goitre Control Program (NGCP)?
 - How is it going to contribute towards PM's 20 point Program?



National Iodine Deficiency Control Program



74

Goitre

Program Developments

- 1962: NGCP launched
- 1984 : Policy of Universal salt Iodization(USI)
: Private sector to produce iodized salt
- 1992: NGCP renamed as NIDDCP
- 1995: Independent survey evaluation of USI in
MP, New Delhi and Sikkim
- 1997: sale and storage of common salt banned
- 1998-99: NFHS II
: 71% using iodized salt
- 13th Sept 2000: ban on sale of common salt
lifted by the GoI, States continued the ban

Goal :

To decrease overall IDD prevalence (goiter) to <5% in the school children 6-12 years.

Objectives :

- Surveys to assess the magnitude of the IDD.
- Supply of iodated salt in place of common salt
- Resurvey after every 5 years to assess the extent of iodine deficiency disorders and the Impact of iodated salt.
- Laboratory monitoring of iodated slat and urinary iodine excretion.
- Health education & publicity.

Spectrum of IDD

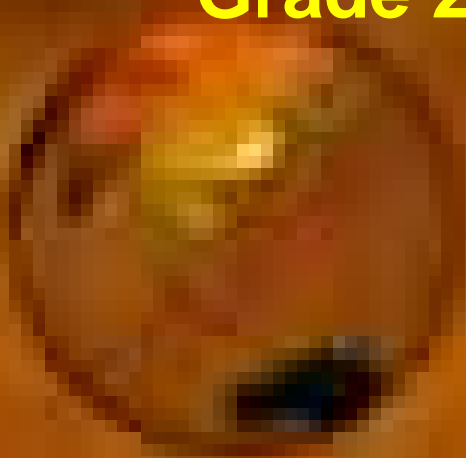
- Fetus:** Abortion, Still Birth, Congenital Anomalies, Prenatal mortality, Infant mortality, Neurological cretinism (mental deficiency, deaf mutism, squint)
- Neonate:** Neonatal Goiter, Neonate Hypothyroidism
- Child and adolescent:** Juvenile Hypothyroidism, Impaired Mental function, Growth retardation
- Adult:** Goiter, Hypothyroidism, Impaired mental function

Classification of Goiter

Grade 0: No palpable or visible goiter

Grade 1: A mass in the neck with enlarged thyroid, palpable but not visible

Grade 2: Swelling in the neck that is palpable as well as visible



Strategy

- A. Essential components of IDDCP
- Ensuring availability of iodized salt
30 PPM at production level
15 PPM of iodine at consumer level
 - Awareness generation to increase consumption level up to 90%
 - Iodized salt is most economical convenient and effective means of mass prophylaxis

B. Iodine monitoring through lab

Iodine excretion determination

Determination of iodine in water, soil and food

Determination of iodine salt

Fortified salt with iron and iodine neonatal hypothyroidism is a sensitive point to environmental iodine deficiency

C. Manpower training

D. Mass communication

Comprehensive Action Plan

- Creating Demand for iodized salt in Community
- Improving Monitoring of quality of iodized salt
- Increasing outlets and access to low cost adequately iodized salt
- Improving iodized salt production
- Advocacy with Policy Makers and Program Managers

Initiatives – Rajasthan

- Reinforce sampling of salt under PFA
- Training of concerned paramedical and health staff at various level with the help of UNICEF
- Component will be included in School Health Program
- District nodal officer are directed to send regular reports to IDD cell

- Strengthening of IDD monitoring lab.
- Monitoring included in IDSP
- 10 Districts has been taken for developing labs in CM&HO's office for examination of Iodized salt
(Bikaner, S.Ganganagar, Barmer, Sirohi, Chittorgarh, Banswara, Jhalawar, Bhartpur, Nagaur, Alwar)

Achievements

- Salt manufacturing license issued to 930 units
- 26 States have totally banned non-iodized salt
- 29 States and UTs have established IDD cells
- Intensive IEC campaigns
- Standards for iodized salt
- National reference laboratory set up
- Ban on sale of non iodized salt



National Program for Prevention of Visual Impairment and Control of Blindness



Global Scenario

- 314 million visually impaired, 45 million blind.
- Aged and females are more at risk
- 87% of visually impaired in developing countries.
82% of visually impaired are 50+
- Age-related impairment is increasing.
- Cataract - leading cause
- Refractive errors correction could give normal vision to >12 million children (ages five to 15).
- 85% of all visual impairment is avoidable

Chronological developments

- 1963: Started as National Trachoma Control Program
- 1976: Renamed as National Program for prevention of Visual Impairment and Control of Blindness(100% Centrally Sponsored)
- 1982: Blindness included in 20-point program

“2020-the right to sight”.

Objectives

- Reducing the Blindness prevalence **from 1.4% to 0.3%** by 2020
- Provide high quality of eye care
- Expand coverage of eye care to the affected population & under-served areas
- Reduce backlog of blindness
- Develop institutional capacity for eye care services

Strategies

- Decentralized DBCS
- Active screening of population above 50 years of age.
- Involvement of voluntary Organization
- Participation of community and PRI
- Development of eye care services and improvement in quality of eye care.
- Screening of school children
- Public awareness
- Specific focus on illiterate women in rural areas.
- To make eye care comprehensive

Indicators

- Cataract operation in bi-lateral blind.
- Cataract surgery in female.
- Cataract surgery in SC/ST population.
- Cataract surgery in different facilities.
- Cataract surgery in different age groups.

Initiatives

- Free surgery for cataract cases in rural areas.
- Free transportation for patients.
- Free medicine for all types of eye ailments.
- Free spectacles for post operative care.
- Free spectacles for poor school students.
- Treatment of backlog cataract cases.
- All schools would be covered for SES.

Initiatives

- Vit- A supplementation and immunization coverage.
- Modern treatment at Medical College and DH.
- one Eye Bank & 2 Eye Donation Centres
- Establishment of one RIO, Cuttack.
- ASHA: be trained and assigned to create awareness. incentive of Rs 175/- per cataract case, out of the fund earmarked under Cataract Operation.
- Contractual Ophthalmology Assistants created

Implementing Agencies

District Blindness Control Society (DBCS)

Composition

Chairman	: District Collector
Vice chairman	: Chief Medical & Health Officer
Members	: Medical Superintendent of District hospital District Education Officer Representatives of NGOs President of IMA Ophthalmic surgeon of Mobile surgical unit An eminent practicing Ophthalmologist
Member secretary	: District Blindness Control Coordinator

Functions of DBCS

- Plan, Implement and Monitor
- Draw list of voluntary agencies/ private hospitals/ NGOs
- Coordination with Health & other departments
- Raise funds and monitor use of funds



Achievements

Year	Total Cataract Surgeries (in lakhs)		Eye/ Cornea Donation	
	India	Rajasthan	India	Rajasthan
2007-08	54.04	3.16	38646	1380
2008-09	58.10	2.23	41780	1386
2009-10	59.06	2.16	46589	1215
2010-11	60.32	2.51	44926	1389
2011-12	32.29	1.82	18190	1016



National Leprosy Eradication Program

National Leprosy Eradication Program

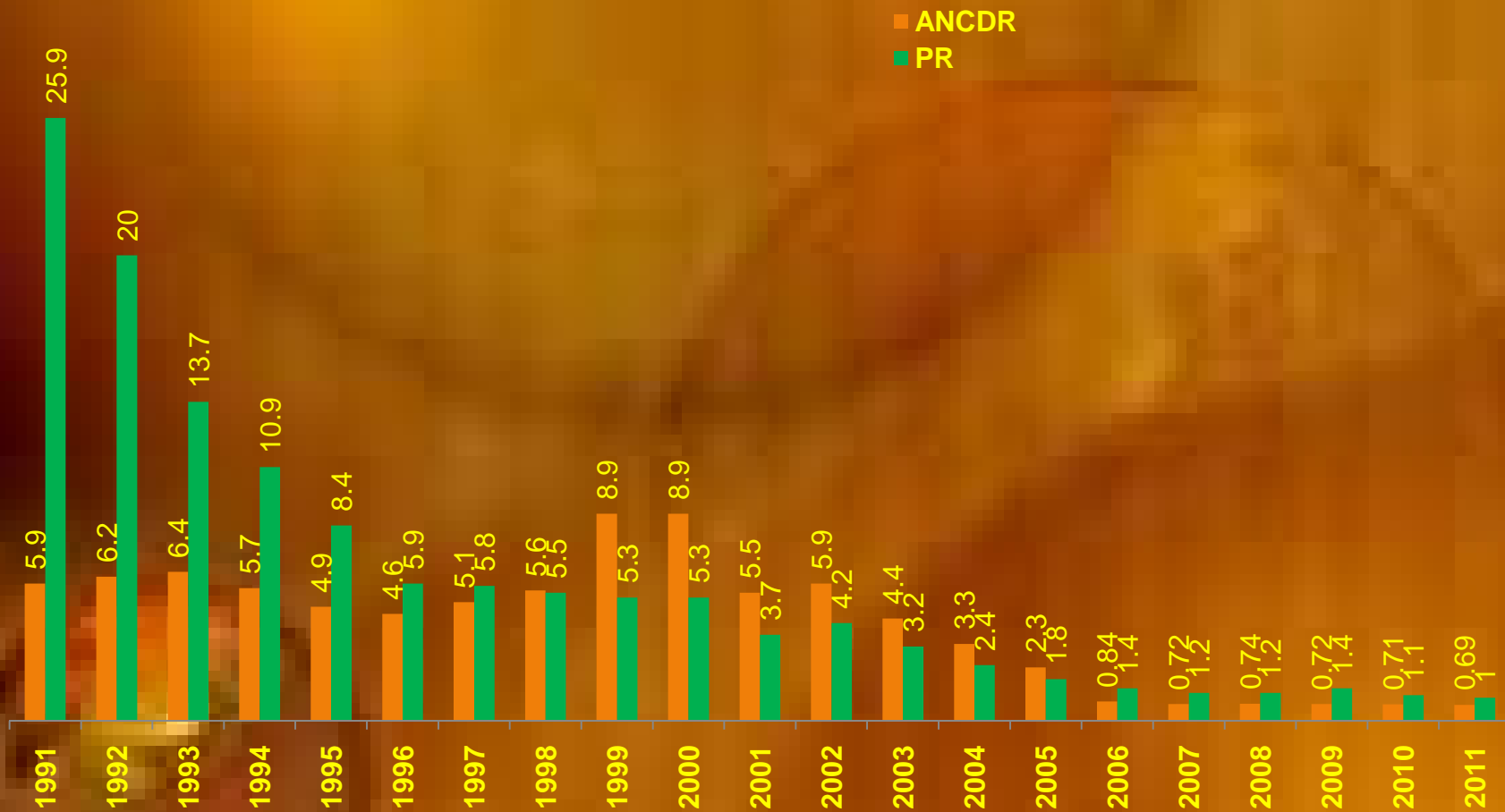


- 1955 -NLCP
- 1970s -Multi Drug Therapy. Dapsone treatment continued.
- 1982 -MDT came into use from 1982,
- 1983 –NLEP
- 1993-2000- The 1st phase of WB supported NLEP implemented
- 1998-2004:Modified Leprosy Elimination Campaign
- 2005 - India achieved elimination National Level.

NLEP: Phased Approach Achievements

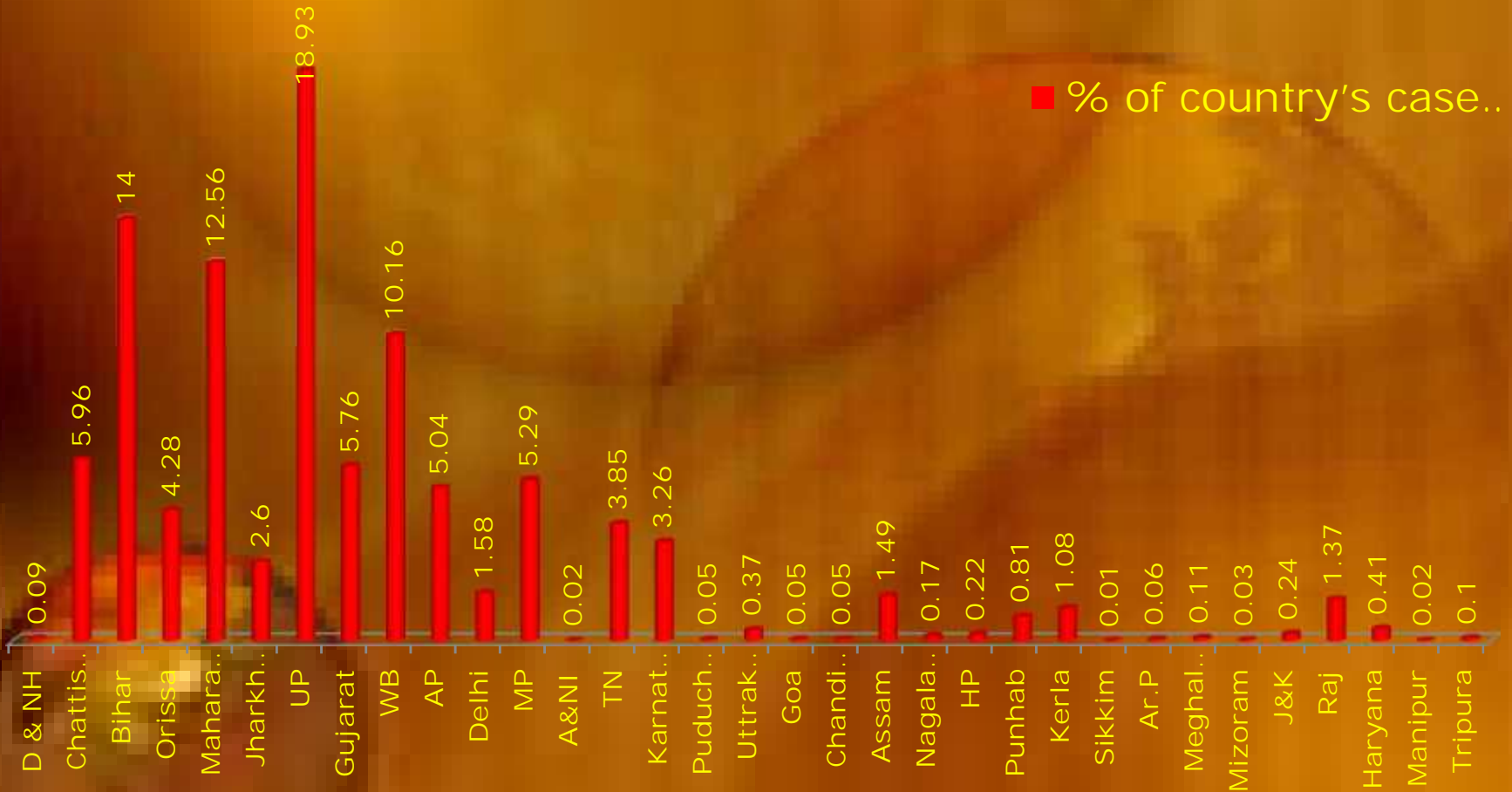
- 1st phase(1993-1994)- prevalence rate reduced 24 (1992) to 3.7/10,000
- 2nd phase (2001-02 to 2003-04) –
Decentralization, integration, Elimination
- PR – 0.84 /10,000 pop. (March 31, 2006)
(Elimination-1/10,000)

Trend of Leprosy Prevalence (PR) and Annual New Case Detection Rate(ANCDR) in India



Source: -NLEP Progress Report 2010-11

State-wise Distribution of country's case load



Source: -NLEP Progress Report 2010-11

Objectives

- Render all case non-infectious in shortest time by:
 - Early detection & treatment
 - Interrupting transmission
- Prevent deformities
- Eradicate Leprosy
- MDT throughout
- Prevalence- $<1/10000$ by 2002



Strategy

- Decentralization of NLEP to States & Districts
- Integration of leprosy services with General Health Care System
- Leprosy Training of GHS functionaries
- Surveillance for early diagnosis & prompt MDT, through routine and special efforts
- Intensified IEC using Local and Mass Media approaches
- Prevention of Disability & Care

Elimination Strategy

- **Strategic Plan of Action (2004-05)**
- Focused Leprosy Elimination Plan (FLEP-2005)
- Intensified Supervision And Monitoring
- Modified Leprosy Eradication Program (1997)



Strategic Plan of Action (2004–05)

- Intensified focused action in 72 districts (PR > 5) and 16 moderately endemic districts with more than 2000 leprosy cases detected during 2003-04.
- Increased efforts put on IEC, Training and Integrated Service Delivery in 86 medium priority districts.
- Intensified IEC through Leprosy Counseling Centres in 836 blocks (PR > 5)

Strategic Plan of Action (2006–07)



- Provision of quality services with
- proper referral for management of reactions,
- complications and correction of deformity
- in districts with PR > 1
- 29 districts and 433 blocks
- Activities proposed:
 - Experienced district nucleus staff
 - Vehicle
 - Orientation for all the PHC Medical Officers
 - Situational analysis within the district
 - IEC , supervision and monitoring



Focused Leprosy Elimination Plan (FLEP-2005)

- 42 high priority districts with PR > 3/10,000 located in 7 endemic states.
- Increased efforts put on IEC, Training and Integrated Service Delivery
- In 552 blocks (PR > 3) as on 31.03. 05, a two weeks long Block Leprosy Awareness Campaign (BLAC-II) through Intensified IEC and Leprosy Counseling Centres at PHC level during the period Sept.-Oct. 2005. M.Os reoriented

Modified Leprosy Eradication Program (1997)

In order to address these challenges a few areas were identified for intensive efforts. These are-

- Training
- Intensified IEC
- Detection and immediate MDT

Approach

➤ Prevalence based categorization

- Endemic : $>5/1000$
- Moderate : $3-5/1000$
- Low : $<2/1000$

➤ Plan of Action

- Preparatory phase
- Intensive phase
- Maintenance phase

Treatment

- MDT since 1982
- Rifampicin, clofazimine and dapsone
- Single dose of MDT kills 99.9% of leprosy germs.
- Free-of-cost on all working days at all SC, PHC, Govt. Dispensaries and Hospitals

Issues in Treatment With Multi Drug Therapy (MDT)



- **Prioritize** (based on resources)
 - Multibacillary
 - Paucibacilliary resistant to Dapsone
 - Other Paucibacilliary
- **Delivery**
 - Adequate, Efficient, Flexible
 - Referral
 - Integration with primary care

Challenges

- Further simplify and shorten the regimen
- Abolish classification for treatment purposes
- Identify areas and communities not yet covered
- Actively change the negative image of leprosy
- Focus more on analysis of detection trends than on prevalence
- Develop an integrated community-based strategy for rehabilitation

States and Districts according to endemicity levels have been categorized and accordingly action plan developed for-

- 8 States with prevalence rate less than 5/ 10000 with
 - Active case finding
 - Promoting self reporting (Voluntary reporting by cases-VRC)
 - IEC & Training

- 6 States with prevalence rate 1-5/10000
 - VRC
 - Staff training & IEC
 - Detection of paucibacilliary cases

- Rest of the states with prevalence rate less than 1/ 10000
 - Intensified IEC
 - Detection of paucibacilliary cases



Revised National Tuberculosis Control Program (RNTCP)

Revised National Tuberculosis Control Program (RNTCP)

Issues in Tuberculosis:

- Case finding-Access to/ Availability of, sputum microscopy
- Treatment-continuity, regularity & compliance
- Drug resistance-MDR-TB (Every one who breathes should be concerned)
- Dual Epidemic-HIV/AIDS & Tuberculosis.

Chronological Developments

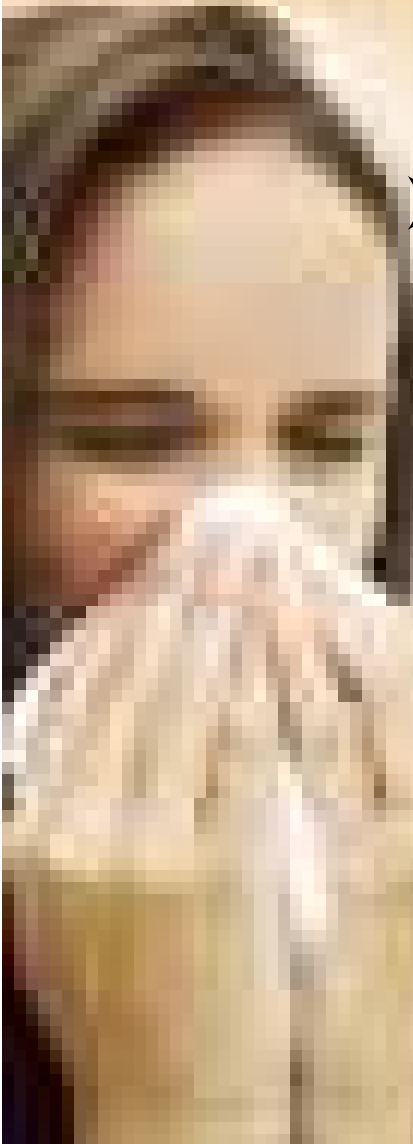
- 1956-61:
 - Tuberculosis Research Center at Chennai (1956)
 - National Tuberculosis Institute established at Bangalore (1959)
 - District Tuberculosis Program (1961)
- 1962: National Tuberculosis Control Program (NTCP)
- 1975: Tuberculosis included in 20-point Program
- 1993: Pilot phase of RNTCP
- 1998: Stop TB initiative
- 1999: RNTCP -second largest program in the World
- 2003: >900,000 cases on treatment- *largest cohort of cases,*

India: 17th among 22 high burden countries in terms of TB prevalence rate (WHO Global TB Report 2010)

National Tuberculosis Control Program (NTCP)

- Domiciliary treatment
- Use of a standard drug regimen of 12-18 months duration
- Treatment free of cost
- Priority to newly diagnosed patients, over previously treated patients
- Treatment organization fully decentralized
- Efficient defaulter system/mostly self-administered regimen
- Timely follow up

RNTCP–Goals

- 
- A blurred image of a person's face and shoulder is visible on the left side of the slide, partially overlapping the text area.
- To achieve and maintain
 - cure rate of at least 85% of new smear positive cases of Tuberculosis
 - detection rate of at least 70% of sputum positive cases after reaching 85% cure rate



Strategy: Directly Observed Treatment with Short course Chemotherapy (DOTS)

- Political & Administrative commitment.
- Good Quality diagnosis
- Good Quality drugs
- Right treatment administered rightly
- Systematic Monitoring and Accountability

DOTS Strategy Interventions

- Case detection
- Adequate Drug supply
- Short Course chemotherapy given under direct supervision.
- Systematic Monitoring and Accountability
- Political will & Advocacy
- System rather than Patient – Accountable for Drug compliance

Achievements under RNTCP

(TB Annual Report 2011)



- Covers entire nation since Mar. 2006
 - In 2010 – 1.52 million patients placed on treatment
- Since inception – 12.8 million on treatment – saving nearly 2.3 million additional lives



Achievements under RNTCP (TB Annual Report 2011)

- Treatment success rates tripled from 25% to 87% in 2010
- NSP CDR of >70% since 2007 (71% in 2010)
- TB mortality reduced from 42 in 1990 to 23/100,000 population in 2010 (WHO Global TB Report 2009).
- The prevalence of TB reduced from 568 in 1990 to 249/100,000 population by 2010 (WHO Global TB Report, 2010)



Achievements under RNTCP (TB Annual Report 2011)

- 11 year analysis shows
 - TB suspects examined by smear microscopy annually increased from 0.96 million to 7.6 million
 - Rate of TB suspects examined increased by 50% from 397/100000 to 642/100000 population covered
 - Rate of sputum positive cases diagnosed by microscopy increased by 27% (from 62 to 80/100000 population)

Treatment Regimen under RNTCP

➤ Category-I

- New sputum smear positive
- Seriously ill sputum -ve
- Seriously ill extra pulmonary



Treatment Regimen under RNTCP

➤ Category-II

- Sputum smear +ve relapse
- Sputum smear +ve failure
- Sputum smear +ve treatment after default

Treatment Regimen under RNTCP

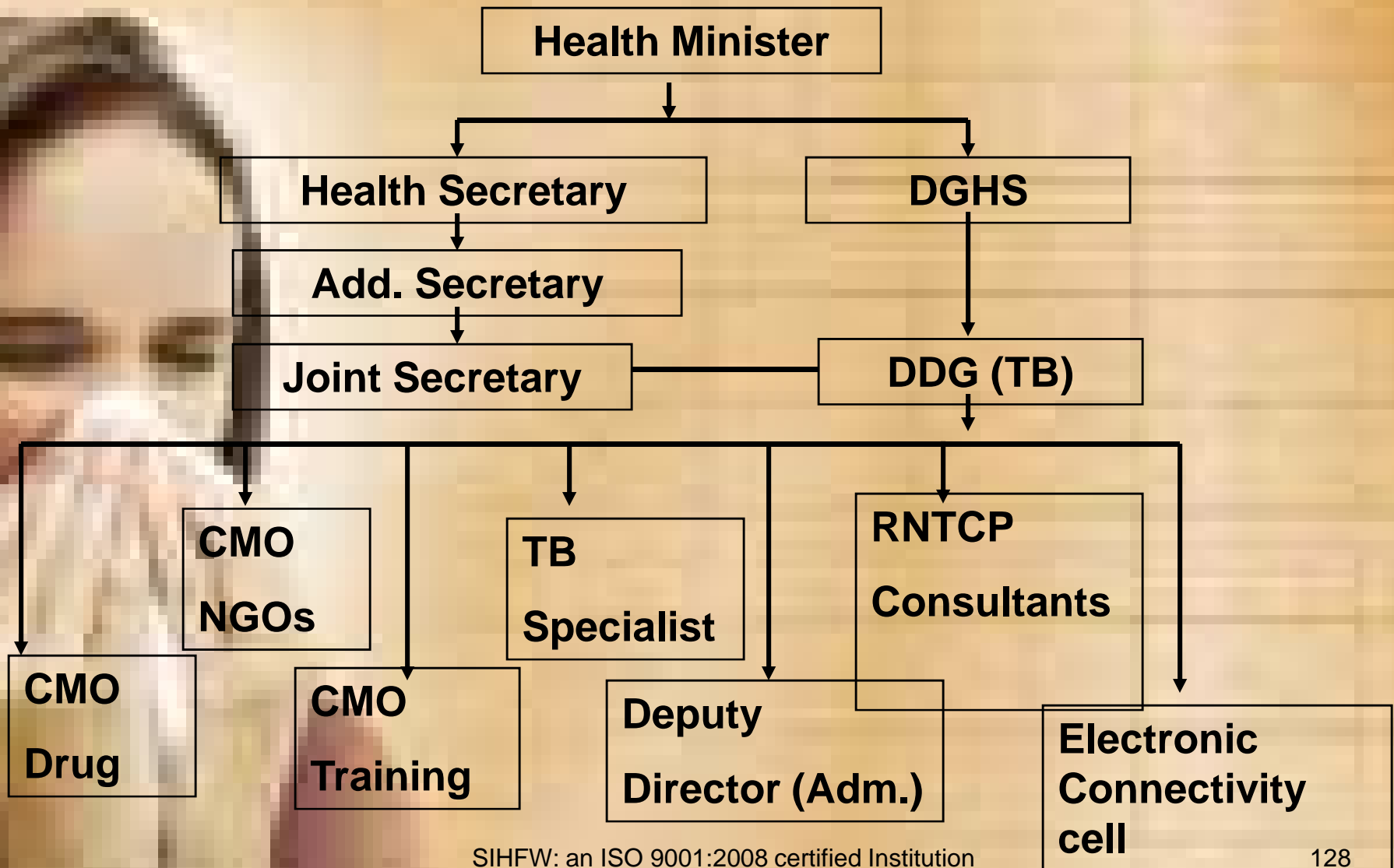
- Category-III
 - Sputum smear –ve not seriously ill,
 - Extra pulmonary not seriously ill

Treatment Regimen under RNTCP

Category	Intensive phase	Continuation phase
I	2 (HRZE) ₃	4 (HR) ₃
II	2 (HRZES) ₃	5 (HRE) ₃
	+	
	1 (HRZE) ₃	
III	2 (HRZ) ₃	4 (HR) ₃

The figures outside the bracket refer to number of months while those after the bracket indicate number of doses per week

Organization Structure



Organization Structure : State Level



Health Minister

Health Secretary

Special Secretary

Nodal Point for TB control

1/0.5 m (0.25 m in Hilly /difficult/tribal area)

1/0.1 m (0.05 m in hilly/difficult/tribal area)

0.25 m (TC), 0.005 m (SC)

DMHS

STO, Deputy STO, MO, Acc., IE C, Off., SA, DEO

DTO, MO-DTC(15%), LT, DEO, Driver

MO-TC, STS, STLS

MO, LT (20%)

DOT Provider – MPW, NGO PP,Comm Vol

State TB Cell

Dist. TB Centre

Tuberculosis unit

Microscopy Centre

DOT Centre

Emerging Issues

- MDR-TB
- TB and HIV
- XDR-TB
- NGO Involvement
- Role of Medical Colleges
- Private sector involvement
- Participation of corporate sector
- Pediatric TB

Terms Used Under RNTCP

- **New case:** A patient with sputum smear +ve and who never had taken anti-tubercular drugs for less than 4 weeks
- **Relapse:** A patient treated and declared cured in past and now returns with sputum +ve smear.
- **Failure:** A patient on anti-tubercular treatment who remains or becomes sputum positive after 5 months or later during Short Course Chemotherapy.

- **Cured:** S_{+ve} patient who completed treatment and had negative smear on two occasions (one immediately after treatment completion).
- Initially S_{-ve} who received full course , or a S_{+ve} who completed treatment with S_{-ve} at the end of initial phase but no or only one negative smear during continuation and none at the end
- **Transfer in:** Patient recorded and registered in one area and transferred into another area for completing treatment
- **Transferred out:** Patient transferred to another area register.



Scheme of Evaluation of RNTCP: Objectives–

- To validate the reported cure rates for last quarter
- To assess program performance and Logistics & Financial Management
- To give recommendations for improving quality of Recording & Reporting
- To give recommendations for improving performance



Evaluation of RNTCP: Internal Evaluation Team-

- State TB Officer
- STDC Director (in states where STDC exists)
- DTO of District other than one being evaluated
- One WHO consultant of District not being evaluated
- One WHO consultant of District other than one being evaluated
- DTO & RNTCP staff of district being evaluated

Evaluation of RNTCP: Selection of Districts

- Frequency- Quarterly
- 2 Districts
 - One with good performance
 - Second with poor performance

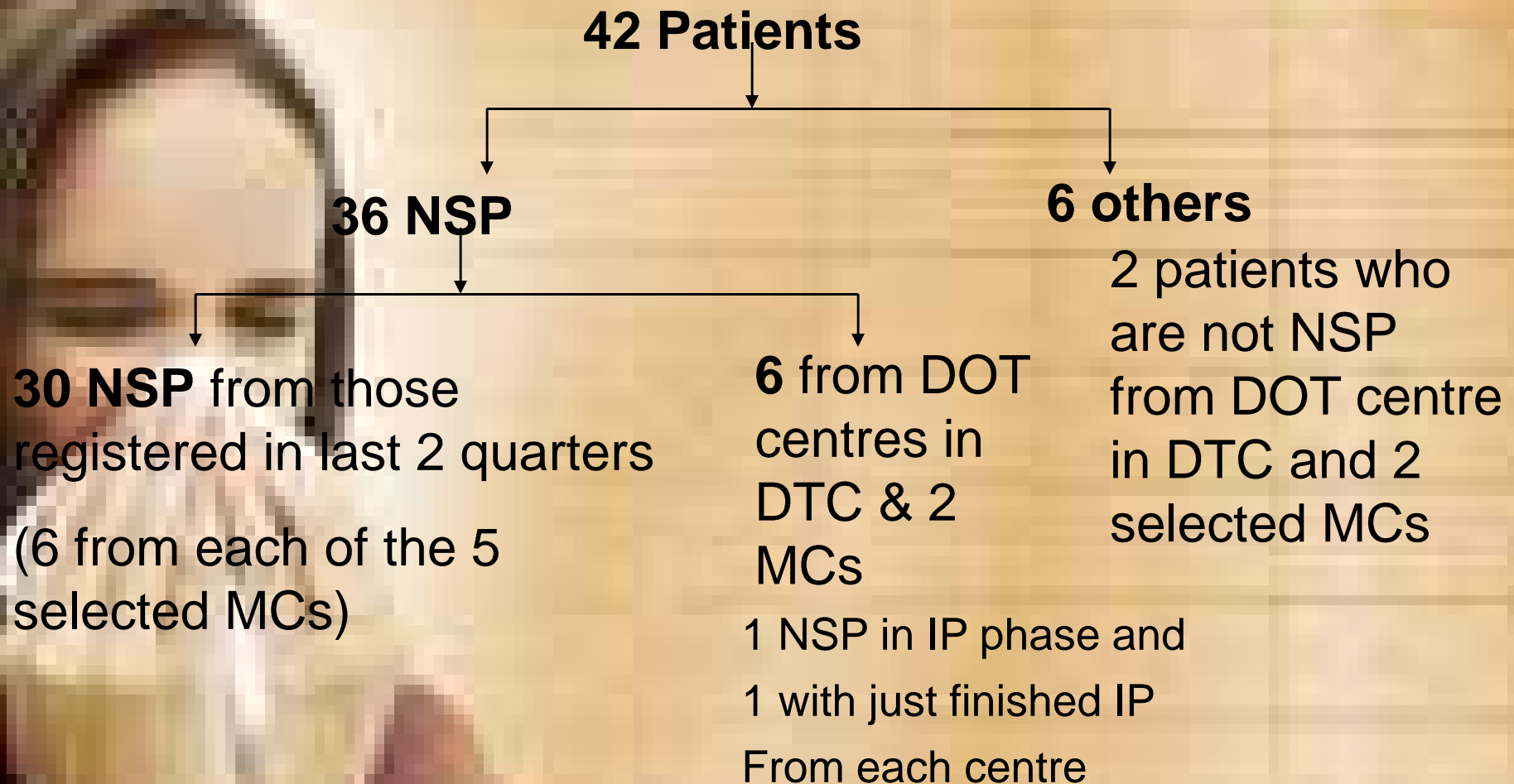
Evaluation of RNTCP: Selection of Microscopy Centres–

- Total of 5 MCs
 - MC in DTC
 - 2 MCs from MCs that are examining higher no. of TB suspects from the enlisted 4, randomly
 - 2 MCs randomly from all the remaining enlisted MCs

Evaluation of RNTCP: Selection of DOT Centers–

- DOT centres in each of the 5 MCs
- 5 other DOT centres like-
 - Attached to medical college
 - STDC
 - ESI
 - Railways
 - NGOs
 - Private sector
 - Aanganwadi
 - DOT centres with 50+ patients

Evaluation of RNTCP: Selection of Patients–



Evaluation of RNTCP: Data Collection-Instruments

- Basic information of District
- Form 1- for review of recording & Reporting
- Form 2-for interviewing DTO & his team
- Form 3-for reviewing MCs
- Form 4-for reviewing DOT centres
- Form 5-for interviewing patients & checking consistency of records between TB Register, Lab. Register and treatment cards of 36 cases

Data Collection–Instruments

- Form 6- for consistency of records between TB Register, Lab. Register and treatment cards of NSP Patients where outcome records are available
- Form 7-for summary of selected indicators
- Form 8-for non NSP Patients
- Form 9-for observations at TU
- Form 10-for recording overall observations



Reporting results of Internal Evaluation:

To Central TB division-

- Form no. 1, 7, 10 just after IE by e-mail.
- Hard copy within 2 days
- Form 1, 2, 6, 7, 8, 9 10 (one copy each)
- Form no. 3 -5 for 5 MCs
- Form no. 10 -10 for 10 DOT centres
- Form no. 5 – 5 copies



National Cancer Control Program



Cancer : India

- 8-9 lakh cases every year
- 25 lakh cases at any point of time
- 4 lakh deaths every year
- 40% cancers related to tobacco use
- Cancers – oral, lungs, cervix, breast account for 50% deaths

National Cancer Registry Program (NCRP)



- Initiated 1982 by ICMR
- Gives magnitude and patterns of cancer
- Types of registries
 - ❖ Population Based Cancer Registry - 21
 - ❖ Hospital Based Cancer Registries - 6



Goals & Objectives of NCCCP

- Primary prevention by health education
- Secondary prevention i.e. early detection and diagnosis
- Strengthening of existing cancer treatment facilities
- Palliative care in terminal stage of the cancer.



Evolution of NCCCP

- 1975-76: National Cancer Control Program launched
- 1984-86: Strategy revised and stress laid on primary prevention and early detection of cancer cases.
- 1991-92: District Cancer Control Program started
- 2000-01: Modified District Cancer Control Program initiated
- 2004 : Evaluation of NCCCP by NIHFW
- 2005 : Program revised after evaluation

National Cancer Control Program 1975–76



Goals & Objectives

- Primary prevention of cancers by health education
- Secondary prevention by early detection and diagnosis of cancers,
- Strengthening of existing cancer treatment facilities
- Palliative care in terminal stage cancer.



Intervention Aimed at Determinants

- **Tobacco**
 - Education- School/ addicts/ women
 - Legislation- Sale/ Advertising/ public place smoking
 - Taxation
- **Diet**
 - Restrict-Fat/ nitrites/Afflatoxins/Additives/ oil reheating
 - Encourage- Fiber/Fruits/ Vegetables
- **Sexual practices**
 - Delay age of marriage/ stick to one/ less no. of children/ BF
- **Occupation & environment**
 - Legislation/ Safety measures
- **Infective agents**
 - Vaccination/Safe Sex

Service Delivery in Cancer Control



- District Cancer Control societies- structure
 - District Collector
 - CM & HO
 - Rep. of Health services/Med. Colleges/
RCC/ NGOs
- Role-
 - Fund generation
 - IEC/ Early detection/ Screening/
Palliative care



Area	Cancer	Agency	Approach	Objectives	Outcome
Pri. Prev.	TRC	People NGOs	Education/ Media	Reduce tobacco use by 30%	Reduce Incidence & mortality
Screening	Cervix	Hlth. Services	One pap at 40 yrs./ pap for high risk	Screen 80%of eligible	Reduce incidence by 50% in 5 yrs.
Early detection	Oral cavity Breast	Doctor/ Paramedic.	Oral self exam./ BSE	Detect 80% in early stage	Reduce mortality by30%
Treatment	Oral cervix breast	MC Local trained doctors	Surgery RT	Effective treatment	Reduce mortality by 30%
Palliative	All incurable	HW/People	Ensure availability	Community care	Quality death



Services Under NCCP- PHC

- Health education
- Health promotion
- Home care
- Early detection
- Palliative care and pain relief



Services Under NCCP- District level

- Health Promotion
- Home Care/
- Early Detection
- Pain Relief/Palliative Care
- Treatment of common cancers
- Histopathology
- Endoscopy



Services Under NCCP- Medical College Without Oncology Unit

- Health Promotion
- Home Care
- Early Detection
- Pain Relief/Palliative Care
- Treatment of common cancers
- Training of medical officers/paramedical personnel
- Preventive oncology-early detection/Registration/ mobile units
- Radiotherapy with cobalt-60 units



Services Under NCCCP- Medical college with Oncology Unit

- Diagnosis and staging by clinical/ histopathological/ biochemical/ radiological/ endoscopical/ immunological/ isotope
- Treatment-Radiotherapy/ surgery/ chemotherapy/ radiation
- Training of Med. /Paramedical
- Maintain hospital based registry



Services Under NCCP– Regional Cancer Centre

- Health Promotion
- Home Care
- Early Detection
- Pain Relief/Palliative Care/Comprehensive Cancer treatment
- Organize screening Program/Cytology training/
- Basic and applied research/Training of all categories of personnel
- Cancer Registries
- Epidemiology



Existing Schemes Under (NCCP)

- Recognition of New Regional Cancer Centres (RCCs)
- Strengthening of existing Regional Cancer Centres
- Development of Oncology Wing
- District Cancer Control Program
- Decentralized NGO Scheme



Achievements

- **Regional Cancer Centres:** 27 RCC, including 6 NGOs
- **Oncology wing:** 246 institutions with radiotherapy facilities
- **District Cancer Control Program:** 28 districts
- **IEC Activities:** health magazine 'Kalyani'



Achievements

- **National Cancer Awareness Day**
- **Onconet- India:** Telemedicine Services including tele-consultations, tele-referral, tele-pathology etc
- **Membership of International Agency for Research on Cancer:** India has become a member



New initiatives

- Logistics- Pap smear kits/Can scan software
- Outreach activities by medical colleges
- Training
- Supply of Morphine
- Telemedicine and supply of computer hardware and software.
- IEC activities.
- Modified District Cancer Control Program
- National Cancer Awareness Day
- Training of cytopathologists and cytotechnicians

Modified District Cancer Control Program



- 4 States-UP/TN/Bihar/WB
- 60 Blocks
- 30 Doctors
- 12 lac women(20-65 Yrs.)
- Health education about-general ailments, cancer prevention and early detection besides 'Breast Self Examination' was imparted



Global WHO Cancer Control Strategy

- **People-centered**
- Equity
- Ownership
- Partnership & Multi-sectoral approach
- Sustainability
- Integration within broad framework of delivery
- Evidence based strategy



National Mental Health Program



Mental Health: Problem Statement

Mental Disorders

- 6-7% of population
- 12% of Global Burden of Disease (GBD)
- 20% of world's children and adolescents
- One child psychiatrist for every 1-4M
- 800,000 people commit suicide every year, 86% of them in low- and middle-income countries.
- Mental disorders-risk factors for CD and NCD

- No Mental Health Policy
- No data collection system
- Mental health disorders
 - Schizophrenia
 - Bipolar disorder
 - Organic psychosis
 - Major depression

Mental Health Resources: India

(per 10,000 population)



- Total Psychiatric beds: 0.25
- Psychiatric beds in mental hospitals: 0.2
- Psychiatric beds in general hospitals: 0.05
- Psychiatric beds in other settings: 0.01
- No. of Psychiatrists: 0.2
- No. of Neurosurgeons: 0.06
- No. of Psychiatric Nurses: 0.05
- No. of Neurologists: 0.05
- No. of Psychologists: 0.03
- Number of Social Workers: 0.03

(Source: Mental Health Atlas, 2005, WHO)



National Mental Health Program

- National Mental Health Program, 1982, re-strategized 2002
- 28 crore (IX FYP), 190 crore (X FYP), 1000 crore (XI FYP)
- District Mental Health Program 1995
- Synchronization with NRHM



National Mental Health Program

- Legislation
 - Mental Health Act , 1987
 - Juvenile Justice Act, 1986
 - The Persons With Disabilities (Equal Opportunity, Protection Of Rights And Full Participation) Act, 1995
 - Narcotic Drugs and Psychotropic Substances Act (Amended 2001)



Objectives

- Ensure availability and accessibility of minimum mental health care for all
- Encourage mental health knowledge and skills
- Promote community participation in mental health service development and to stimulate self-help in the community.



Strategies

- Expansion of DMHP to 100 districts all over the country.
- Modernization of Mental Hospitals.
- Up-gradation of Psychiatry wings of Govt. Medical Colleges/General Hospitals.
- IEC Activities.
- Research & Training in Mental Health for improving service delivery



District Mental Health Program

DMHP – 123 districts

Up-gradation of Psychiatric wings of 75
Government Medical Colleges/General
Hospitals

Modernization of 26 Mental Hospitals.



Components

- Establish Centres of Excellence in Mental Health by upgrading and strengthening of mental hospitals
- Provide impetus for development of Manpower in Mental Health
- Spill over of 10th Plan schemes for modernization of state run mental hospitals and up gradation of psychiatric wings of medical colleges/general hospitals.
- Counseling in schools, colleges, work place



Components

- Research-huge gap needs to be addressed
- IEC-remove stigma attached to mental illnesses.
- NGOs and Public Private Partnership for implementation of the Program to increase outreach of community
- Monitoring Implementation & Evaluation



Thank You

For more details log on to
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